"Bashing" of Medical Specialties: Students' Experiences and Recommendations

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Background and Onjectives: *Exposure to non-constructive criticism of medical specialties is believed to be fairly common among medical students. Better understanding of this "bashing" phenomenon is needed to promote greater professionalism in medical education and student interest in primary care careers. This study examines exposure and reactions to bashing among third-year medical students in a public university.* Methods: *A survey assessing amount, sources, targets, and nature of perceived bashing was completed by 105 students. Three open-ended questions elicited students' experiences, opinions, and recommendations.* Results: *Students perceived that bashing of other specialties occurred during all clerkships; the most were perceived during the surgery clerkship, for which 87.5% reported such bashing. Specialties perceived as the object of bashing were family medicine (72%), general internal medicine (40%), psychiatry (39%), and general surgery (36%). Sixty-seven percent of students reported personally receiving non-constructive criticism about their preferred specialty. Seventy-nine percent believed bashing was unprofessional behavior. Strategies suggested by respondents to decrease bashing included increasing awareness, highlighting the interdisciplinary nature of medicine, and evaluating professionalism.* Conclusions: *Medical students perceived bashing of medical specialties, recognized it as unprofessional behavior, and would be receptive to interventions to reduce bashing. Findings suggest a need to address bashing as part of professionalism curricula in medical training.*

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A significant portion of medical training occurs outside the realm of formal teaching, involving non-didactic interaction with faculty, residents, and other students.[1] Role models are an important part of this training.[2] Indeed, role models are central to two important needs in medical education: the inculcation of professionalism[3] and promotion of interest in primary care.[4]

The informal influences of role models, however, are not always positive. Hearst et al drew attention to this more than a decade ago with a study involving students at the University of California-San Francisco Medical School. In that study, 95% of students interested in family medicine had by their fourth year encountered negative feedback regarding the specialty, typically from physicians in other specialties.[5] Similar findings have since been reported by others. One study showed that 76% of medical students heard "badmouthing" about their particular career choices, with 74% reporting they heard badmouthing of particular specialties from residents, 72% from students, and 57% from faculty.[6] Similarly, another study found that the most frequent sources of negative comments were students (55.4%), residents (55.3%), and faculty (42.5%).[7]

Students' specialty choice may be affected by such nonconstructive criticism of health care specialties.[8] Hearst et al demonstrated that negative comments influenced medical students to change career selection more often than positive comments. Specifically, students reported that 84% of changes in career choice were due to negative comments about their initial specialty choice, and 16% were due to positive comments about their new choice.[8] Likewise, an Australian study found that 21% of students reported changing their specialty due to badmouthing,[9] and an American study indicated that 17% of medical students reported altering their career choice because of badmouthing.[6]

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While the research on this topic remains limited, it does raise concerns that exposure to nonconstructive criticism is a fairly common experience for medical students. The terms "bashing" and "badmouthing" still need more precise definition, but the existing studies suggest that the phenomenon is generally recognized as representing distinctly negative feedback and comments directed by members of one medical specialty toward other specialties. Studies have documented this by asking students to report perceptions of negative comments, badmouthing, negative factors, negative feedback, and encouragement or discouragement toward a particular specialty.[5,6,7,8]

Such bashing or badmouthing has important implications for family medicine, which has been found to be among the most criticized specialties.[6,7] One study found that 87% of respondents reported encountering criticism of family medicine, second only to surgery in frequency (91%).[3] Another study determined that only 34.5% of those originally interested in family medicine actually entered this specialty.[10] In Hearst's study, only 39% of fourth-year students who had previously been interested in family medicine actually chose family medicine as their specialty.[5]

The current study was undertaken to gather preliminary data on whether bashing was occurring at a public northeastern US medical school that has long emphasized promotion of student interest in primary care. Specifically, the purpose of this study was to (1) determine the extent and sources of bashing (nonconstructive criticism) of medical specialties as perceived by third-year medical students, (2) determine whether or not students perceived bashing as unprofessional behavior, and (3) elicit student-driven strategies to address the issue. This study uses the lay term "bashing," further defined for students in the questionnaire, explained below.

Methods

A self-administered survey was given in June 2005 to third-year medical students during an end-of-year mandatory class meeting at a large northeastern public university. Of 134 registered third-year medical students, 105 completed surveys, yielding a response rate of 78%. Survey participation was voluntary and completely anonymous. The study was approved by the university's Institutional Review Board.

Bashing was defined in the survey as nonconstructive criticism directed at specific medical specialties. Students were asked to report how much bashing about any specialty they perceived during each of their third-year clerkships (family medicine, internal medicine, obstetrics-gynecology, pediatrics, psychiatry, and surgery). The survey assessed how much bashing of medical specialties medical students perceived being done by clerkship directors, faculty, residents, and fellow medical students. Students also were asked how much nonconstructive criticism they perceived outside the clerkships coming from basic science faculty, faculty and staff in the Office of Medical Education and Dean's office, and other students, as well as from family members. Perceived amount of bashing was assessed on a Likert scale from 1 to 5 (1 was defined as none, 3 occasionally, and 5 a lot). Students were provided a list of 24 specialties and asked to identify the three specialties they perceived being bashed the most.

Students were asked if they personally had received nonconstructive criticism for contemplating a career in a particular specialty (they were not asked to name the specialty). They also were asked if bashing "should be tolerated and accepted within the medical profession" (this was intended to elicit whether respondents considered bashing to be "professional" behavior). Students ranked whether the nonconstructive criticism they perceived affected specialty choice on a scale of 1 to 7 (with 1 defined as "It made me want to go into the specialty even more," 4 defined as "It had no effect on my specialty choice," and 7 defined as "It made me want to avoid the criticized specialty"). These responses were collapsed into three categories: made me choose the specialty (1–2), no effect (3–5), and made me avoid the specialty (6–7).

Three open-ended questions also were included at the end of the survey: (1) "What are some examples of the bashing (for contemplating a career in a certain medical specialty) you heard or criticism you received (if any)?" (2) "If you observed any bashing, why do you think it occurred?" and (3) "If you don't think bashing should be tolerated and accepted, what ideas do you have to decrease its occurrence?" Of all the respondents, 53% answered the first question, 58% answered the second question, and 34% answered the third question.

Data Analysis

All quantitative analyses were conducted using SPSS (version 14, 2005, SPSS, Inc, Chicago). Descriptive data (frequency and percentage) were reported for ranked and categorical variables. Friedman's chi-square was conducted to assess statistical significance across specialties. This test was used because the scales are not continuous but rather, represented ranked data and this test allows the comparison of similar scales across multiple variables. P values of $<.05$ were considered statistically significant.

Written responses to the open-ended questions were transcribed and entered into NVivo 2 (version 2, 2002, QSR, Melbourne, Australia). One member of the research team, a qualitative research specialist, led the analytical team and trained two other researchers in qualitative data analysis. Responses to each question were analyzed together. The analysts reviewed the responses to each open-ended question separately and

independently, following a content-driven immersion-crystallization approach. This analytical approach consists of a systematic iterative process of text review and interpretation "involving repeated delving into and experiencing of the data" to identify and reflect on key references that pertained to the study questions.[11] The analysts identified relevant passages that directly addressed the specific question and then developed categories or themes that summarized the main findings through consensus.

Results

As shown in Table 1, third-year medical students reported perceived bashing of other medical specialties during all six clerkship rotations (family medicine, internal medicine, obstetrics-gynecology, pediatrics, psychiatry, and surgery). Overall, bashing was perceived by 80.6% of the students to occur occasionally to a lot during their surgery clerkship, compared with 61% during the internal medicine clerkship, 44.8% during the obstetrics-gynecology clerkship, 25% during psychiatry, 22.4% during family medicine, and 22.3% during pediatrics.

Bashing by Faculty

When asked about bashing by faculty during teaching sessions, 42% of students reported bashing to occur occasionally to a lot by family medicine faculty com-

Table 1

Amount of "Bashing" Perceived by Third-year Medical Students During Required Clerkships Based on a 1 (None) to 5 (Often) Likert Scale (n=105)

	Third-year Clerkship Rotations						
Amount of "bashing" observed…	*Family Medicine n (%)*	*Internal Medicine n (%)*	*OB-GYN n (%)*	*Pediatrics n (%)*	*Psychiatry n (%)*	*Surgery n (%)*	P *Value*
In general, during clerkship rotations							< .001
1 (none)	40 (39.2)	12 (11.4)	19 (18.4)	32 (31.1)	35 (33.7)	3 (2.9)	
2	39 (38.2)	29 (27.6)	37 (35.2)	48 (46.6)	43 (41.3)	10 (9.6)	
3 (occasionally)	18 (17.6)	44 (41.9)	34 (32.4)	17 (16.5)	23 (22.1)	27 (26.0)	
4	4 (3.8)	17 (16.2)	10 (9.5)	4 (3.9)	3 (2.9)	38 (36.5)	
5 (a lot)	1 (1.0)	3 (2.9)	3 (2.9)	2 (1.9)	0 (0)	26 (25.0)	
By faculty during teaching sessions							< .001
1 (none)	35 (34.3)	63 (62.4)	49 (47.1)	54 (52.4)	62 (61.4)	65 (64.4)	
2	24 (23.5)	30 (29.7)	30 (28.8)	34 (33.0)	30 (29.7)	29 (28.7)	
3 (occasionally)	27 (26.5)	5 (5.0)	17 (16.3)	11 (10.7)	7 (6.9)	7 (6.9)	
4	10 (9.8)	3 (3.0)	7 (6.7)	2 (1.9)	2 (2.0)	0 (0.0)	
5 (a lot)	6 (5.9)	0 (0)	1 (1.0)	2 (1.9)	0 (0.0)	0 (0.0)	
By faculty during clinical time, rounds, or case conferences							< .001
1 (none)	55 (53.4)	29 (28.7)	57 (57.0)	34 (32.7)	41 (39.8)	51 (50.0)	
2	31 (30.1)	21 (20.8)	33 (33.0)	39 (37.5)	40 (38.8)	37 (36.3)	
3 (occasional)	16 (15.1)	31 (30.7)	8 (8.0)	25 (24.0)	18 (17.5)	13 (12.7)	
4	0 (0.0)	15 (14.9)	2 (2.0)	4 (3.8)	3 (2.9)	1 (1.0)	
5 (a lot)	1 (1.0)	5 (5.0)	0 (0.0)	2 (1.9)	1 (1.0)	0 (0.0)	
By residents							< .001
1 (none)	40 (40.0)	47 (45.6)	6 (5.8)	48 (48.5)	24 (22.9)	25 (24.3)	
2	30 (30.0)	31 (30.1)	14 (13.6)	28 (28.3)	32 (30.5)	30 (39.1)	
3 (occasionally)	20 (20.0)	16 (15.5)	21 (20.4)	13 (13.1)	26 (24.8)	29 (28.2)	
4	7 (7.0)	7 (6.8)	32 (31.1)	7 (7.1)	17 (16.2)	14 (13.6)	
5 (a lot)	3 (3.0)	2 (1.9)	30 (29.1)	3 (3.0)	6 (5.7)	5 (4.9)	
By clerkship director							< .001
1 (none)	83 (86.5)	80 (84.2)	83 (86.5)	73 (76.8)	81 (86.2)	76 (78.4)	
2	11 (11.5)	13 (13.7)	11 (11.5)	16 (16.8)	11 (11.7)	12 (12.4)	
3 (occasional)	2 (2.1)	2 (2.1)	2 (2.1)	4 (4.2)	2 (2.1)	4 (4.1)	
4	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.1)	0 (0.0)	4 (4.1)	
5 (a lot)	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.1)	0 (0.0)	1 (1.0)	

pared to 24% by obstetrics-gynecology faculty, 13.5% by pediatrics faculty, 8.9% by psychiatry faculty, 8% by internal medicine faculty, and 6.9% by surgery faculty. When asked about bashing by faculty during clinical time, students reported that they perceived bashing to occur occasionally to a lot, most often (50.6%) by internal medicine faculty. The corresponding numbers for faculty in other specialties were 29.7% for pediatrics faculty, 21.4% for psychiatry, 16.1% for family medicine, 13.7% for surgery, and 10% for obstetrics-gynecology. Students identified clerkship directors in all clerkships as the least common sources of bashing.

Bashing by Residents

In response to the question about bashing by residents, 81% of students perceived bashing of other medical specialties occasionally to a lot by obstetrics-gynecology residents, 46.7% by surgery residents, 46.7% by psychiatry residents, 30% by family medicine residents, 24.2% by internal medicine residents, and 23.2% by pediatric residents.

Bashing by Others

Students reported relatively little bashing by the faculty and staff in basic science departments or from the Office of Medical Education (Table 2). Seventy percent of students perceived bashing of medical specialties by other medical students. Twenty percent of students perceived bashing by their family members.

Targets of Bashing

Table 3 shows that family medicine was identified by the greatest portion of respondents (72%) as being among the specialties bashed most often. Other specialties reported to be the most frequently bashed included psychiatry (39%), general surgery (36%), general internal medicine (35%), and emergency medicine (25%).

Table 4 shows that two thirds of students received nonconstructive criticism for contemplating a certain specialty. The majority of students (62.6%) reported that bashing did not influence their specialty choice, but 23% reported that bashing did make them want to avoid their initially chosen specialty. Most students (76.7%) felt that bashing should not be tolerated and was unprofessional behavior.

Responses to Open-ended Questions

Responses to the three open-ended questions in the survey are presented as themes in Table 5. The themes that emerged from the analyses of examples of bashing offered by the respondents included (1) lower skill sets needed for a particular specialty (such as "Obstetrician-gynecologists aren't real surgeons" and "You're too smart to do pediatrics; do surgery"), (2) reservations about a specialty's approach (such as "Family medicine doctors are 'referral specialists'" and "Radiologists don't treat patients, they treat radiographs"), (3) lifestyle concerns related with a specialty (such as "[You] don't make any money [in family medicine]" and have "… long hours and hard lifestyle"), and (4) personality issues of people in a specialty (such as "Anesthesiology is for slackers" and "Your personality is not right for surgery—they are cold, unattached…").

Students' responses regarding why they thought bashing occurred revolved around the following constructs (Table 5): (1) high regard for specialty choice (such as "people need to feel like they went into the best specialty" and "[Surgery] residents feel high and mighty"), (2) insecurity about own specialty choice (such as "People are not happy with their career selection" and "Insecurity over their specialty"), (3) lack of understanding of other specialties (such as "Inability to recognize the need for all fields" and "Assumptions about other fields"), and (4) reservations about a specialty's approach (such as "Differences in [patient] management styles" and "Frustration at other specialty's line of reasoning").

Lastly, students' suggestions for decreasing the occurrence of bashing are represented by the following

Table 2

Amount of Bashing by Faculty, Peers, and Family Members Perceived by Third-year Medical Students Throughout Their Medical Education Based on a 1 (None) to 5 (Often) Likert Scale (n=105)

Source of Bashing	*1 (None) n (%)*	*2 n (%)*	*3 (Occasionally) n (%)*	*4*	*5 (A Lot) n (%)*
Faculty in the Office of Medical Education or Dean's Office including staff	88 (89.8)	7 (7.1)	1 (1.0)	2 (2.0)	0 (0)
Basic science faculty and staff	70 (72.9)	21 (21.9)	5 (5.2)	0 (0)	0 (0)
Medical students (peers)	10 (9.7)	21 (20.4)	44 (42.7)	17 (16.5)	11 (10.7)
Family members	52 (54.2)	25 (26.0)	14 (14.6)	3 (3.1)	2 (2.1)

Table 3

Specialties Identified by Students as Being Bashed Most Often* (n=105)

Specialty	*n (%)*
Family medicine	76 (72%)
Psychiatry	41 (39%)
General surgery	38 (36%)
General internal medicine	37 (35%)
Emergency medicine	26 (25%)
Gynecology-obstetrics	14 (13%)
General pediatrics	11 (10%)

*These categories are not mutually exclusive. Given a list of 23 specialty areas in alphabetical order, students were asked to circle up to three specialties that they observed got bashed the most (if any). Only specialties reported by 10% or more of students reported are listed.

Table 4

Students' Personal Experience With Bashing (n=105)

Experience	*n (%)*
Received nonconstructive criticism for contemplating a career in a certain medical specialty	
• Yes	68 (66.7)
• No	21 (20.6)
• Not sure/don't remember	13 (12.7)
Impact of "bashing" on your specialty choice	
• Made me want to go into the specialty more	14 (14.1)
• No effect	62 (62.6)
• Made me want to avoid specialty	23 (23.2)
Feel bashing should not be tolerated (ie, is unprofessional behavior)	
• Yes	79 (76.7)
• No	8 (7.8)
• Unsure	16 (15.5)

themes: (1) top-down discouragement of disparaging remarks (such as "The attendings need to discourage it all the way down" and "Faculty, attendings, residents should set a high standard"), (2) increase awareness of its negative impact on specialties (such as "Make people aware of how unprofessional it is" and "Increase awareness . . . of the nonconstructive nature of such criticisms"), and (3) training on the value of interdisciplinary health care teams (such as "More interdisciplinary gatherings" and "Emphasis on working together for the welfare of patients"). Other students reported indifference toward or lack of perceived utility of remedial action (such as "Not everything that we should not tolerate requires an active program to correct it" and "People are entitled to their opinions").

Discussion

This study of third-year students in a large public medical school lends support to concerns about the existence and negative effect of nonconstructive criticism directed at particular medical specialties. Students reported being exposed to at least some level of bashing in all required third-year clerkships, including family medicine. Moreover, two thirds reported personally receiving such criticism at some point (not necessarily during clerkships) for their own specialty choice. Nearly one quarter reported that bashing had made them want to avoid their initially chosen specialty. Residents and other medical students were identified as the most common sources of bashing. The majority (76.7%) of respondents considered bashing to be unprofessional behavior that should not be tolerated. Students offered creative suggestions on how to reduce bashing, such as educating people about the problem, developing multidisciplinary teams, and evaluating bashing.

These findings are generally consistent with earlier research. For example, Wilkinson et al found that 67% of students had at least one adverse experience during their training. In that study, humiliation was the most common adverse experience and had the greatest effect. The most common perpetrators were senior physicians and nurses.[12] Students and residents were found to be the primary offenders in terms of bashing in research done by Hunt et al[6] and Campos-Outcalt et al.[7] Other studies have shown that bashing may affect career choice.[5,6,8,9]

The importance of influences outside the formal curriculum in shaping student interests and values has been recognized, although the complexities of these influences are yet to be fully understood. Positive role models are a key factor for maintaining interest in a particular specialty, but this influence can be reduced when students are exposed to high levels of comments reflecting negative stereotypes.[4] Peer encouragement is also important to career choice. However, when peer reaction is simply neutral the effect may be to reinforce prevailing pressures toward specialty medicine, rather than primary care, in many academic health centers.[13] Likewise, much of what students learn about professionalism occurs outside the classroom and is often counter to what they are being formally taught. Kenny et al have suggested that while role modeling is central to professional character development, from an educational perspective it remains a "conceptual black box."[3] Among other things, they call for developing ways to help students identify negative role models and translate experiences with them into effective learning.

Primary care specialties have been identified as being bashed more often than other specialties. This may have a significant influence on students considering careers in primary care. As more primary care physicians retire and fewer medical students enter primary care residen-

Table 5

Themes About the Nature of and Potential Solutions to Specialty Bashing

"What are some examples of the 'bashing' you heard… (if any)?" (n=56) • Lower skill sets needed for a specialty • Reservations about a specialty's approach • Lifestyle concerns related with a specialty • Personality issues of persons in a specialty
"If you observed any 'bashing,' why do you think it occurred?" (n=61) • High regard for own specialty choice • Insecurity about own specialty choice • Lack of understanding of other specialties • Reservations about a specialty's approach
"What ideas do you have to decrease its occurrence?" (n=36) • Top-down discouragement of disparaging remarks • Increase awareness of its negative impact on specialties • Training on the value of interdisciplinary health care teams

cies, the primary care shortage will continue. Reducing bashing may be one way to encourage more students to enter primary care and avoid a major shortage of primary care physicians.

In alignment with the Accreditation Council for Graduate Medical Education (ACGME) core competencies, medical educators need to consider how to teach and evaluate professional behavior among their students, residents, and faculty. Medical educators and administrators are now recognizing the importance of professional behavior as it impacts patient care, professional relationships, teamwork, and medical finances. As a result, medical schools and hospital systems across the country are developing strategies to improve professional behavior among all learners, staff, faculty, and physicians. Students who participated in this study offered a variety of strategies to address bashing in a positive, proactive setting that develops professional respect through interaction, still recognizing the need for corrective action if necessary. This suggests that students value professionalism and the need to incorporate curricula to address it.

Measures to assess professionalism, particularly respect for other disciplines during training, need to be developed and validated. Similarly, criticism of colleagues and treatment of other health care professionals and patients needs to be incorporated into a larger construct of professionalism. A consistent format for evaluation would help medical schools compare strategies to improve professionalism among medical professionals and students. This study created a tool to better understand one aspect of professionalism. Future studies are needed to test the validity and reliability of this tool within this institution and across medical schools and to determine the extent of the effect that bashing has on student specialty choice.

Limitations

The current study represents an effort at one public medical school to begin that process by gathering baseline data and seeking student input, and the study has several limitations. First, the survey was done at the end of the third year, and recall bias may be present since students were exposed to various disciplines at different times. Second, bashing (nonconstructive criticism) is not a well-defined construct. As such, there are no validated measures of bashing (nonconstructive criticism) that would have lessoned the potential for measurement error in this study. We recognize that although the definition of bashing in this study was limited to nonconstructive criticism directed at other medical specialties, students may interpret the content and amount of bashing differently.

Third, this study does not acknowledge the broader scope of professional behavior in addressing nonconstructive criticism toward colleagues within a medical specialty, nurses, or even patients. Students spend more time with residents and fellow medical students than they do with faculty, which may, at least partially, explain why they heard more bashing from residents and students.

Fourth, many things not assessed in this study may also affect a student's career choice (such as prestige of specialty, income, and lifestyle). Therefore, residual confounding of these factors may be inherent in the findings of our study. We assessed only student perception of the effect of bashing on students' career path. Students were not followed to determine what specialty was actually chosen. Finally, student response rates for the three open-ended questions were lower than the overall survey completion rate.

Conclusions

In summary, bashing in this study was perceived among students in all third-year clerkships and was considered to be unprofessional behavior by the majority of the students. Medical schools and hospitals need to create a nonjudgmental professional environment where every discipline is respected, and students are able to freely express a career preference that is in alignment with their personal goals and is not hindered by unprofessional criticisms. One way to create this environment may be to educate faculty, residents, and students about the problem and then provide them with feedback and evaluation.

Much work remains to be done in the area of professionalism in the medical curriculum. Future studies include identifying student characteristics that might affect how nonconstructive criticism is perceived and influences choice of specialty. Formative work is also

needed to better define bashing and subsequent testing of validity and reliability of measures. Assessing professional behavior should include treatment of peers, nurses, and patients. Lastly, the effect of unprofessional behavior on career choice is also important to consider among cohorts of students.

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